VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

March 31, 2014

Paul Bengtson, Administrator
Northeastern Vermont Regional Hospital
1315 Hospital Drive
Saint Johnsbury, VT 05819

Dear Mr. Bengtson:

The Division of Licensing and Protection completed a survey at your facility on **March 6, 2014**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **March 31, 2014.**

Sincerely,

Frances L Keeler

Frances L. Keeler, RN, MSN, DBA
Assistant Division Director
Director State Survey Agency

FK:jl

Enclosure

RECEIVED Division of Licensing and Protection MAR 26 14
PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471303	A. BUILDING _____ B. WING _____	C 03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHEASTERN VERMONT REGIONAL HOSPITAL	1315 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on March 5 and 6, 2014. Regulatory violations were cited.	C 000		
C 152	485.608(b) COMPLIANCE W ST & LOC LAWS & REGULATIONS All patient care services are furnished in accordance with applicable State and local laws and regulations. This STANDARD is not met as evidenced by: Based on record review and staff interview, the Critical Access Hospital failed to be in compliance with the State of Vermont Statute Title 18, Chapter 42: Bill of Rights for Hospital Patients for one of six medical records reviewed. Per State Statute 1852, Patients' Bill of Rights for Hospital Patients: (1). "The patient has the right to considerate and respectful care at all times and under all circumstances with recognition of his or her personal dignity." Findings include: The patient presented to the facility emergency department on December 6, 2013 with a chief complaint of anxiety. {S/he became progressively more anxious and hostile toward hospital staff upon realizing that [s/he] had to register to see the counselor who directed the patient to meet [him/her] in the emergency department. The patient did not want to wear the wristband identification bracelet, and did not want to relinquish [his/her] clothes assuming that the emergency department visit was going to be with the mental health counselor only. The patient	C 152	***C152: 485.608(b) COMPLIANCE W ST & LOC LAWS& REGULATIONS*** ***All patient care services are furnished in accordance with applicable State and local laws and regulations.*** Based on staff interviews and record review the facility failed to be in compliance with the State of Vermont Statute Title 18, Chapter 42: Bill of Rights for Hospital Patients for one of six records reviewed. Per State Statute 1852, Patients' Bill of Rights for Hospital patients: (1) "The patient has the right to considerate and respectful care at all times and under all circumstances with recognition of his or her personal dignity." Patient #1 presented with a chief complaint of anxiety and became progressively more anxious and hostile towards hospital staff when asked to register and be examined in the ED. The patient was instructed by the NEKHS Crisis Worker to go to the NVRH Emergency Department and the worker would meet the patient there. **Continued on page 2 of 5** POC accepted 3/31/14 D. Delano/FK via RVNSA 3.31	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 3/24/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 152	Continued From page 1 became more intense and volatile and had verbalized an intention to drive [his/her] automobile off of a bridge. The patient was not allowed to leave the emergency department pending a mental health evaluation which caused [him/her] to become louder, demanding, and finally threatening toward staff. The patient was ultimately put down to the floor by the physician and a sheriff officer who handcuffed the patient per the request of the physician. The facility has a restraint policy in place that does not include the use of law enforcement handcuffs as a means of clinical intervention. The patient was not afforded an acceptable standard of clinical practice, that being, trained emergency room staff utilizing de-escalation principals and then if warranted the clinical staff applying restraining devices. Per interview of the physician who physically intervened and requested the handcuffs, [s/he] stated that it was emergent and that the hospital restraints were across the room in another examination room. The physician stated the [s/he] was familiar with hospital policy regarding the use of restraints, but confirmed [s/he] did not follow that protocol in this instance.	C 152	Continued from page 1 of 5 ***C152: 485.608(b) COMPLIANCE W ST & LOC LAWS& REGULATIONS*** Patient #1 became threatening towards staff and was ultimately taken to the floor by the physician and Sheriff. Patient #1 was then handcuffed by the Sheriff as directed by the physician. The handcuffs remained in place for approx. 5 min. Patient #1 was not approached by trained emergency department staff utilizing de-escalation principles prior to determining whether or not the patient would need to be placed in restraints in accordance with the current approved policy on Restraints. **Corrective Action Plan**: 1. De-escalation Training will be required for ED nurses, ED Technicians, ED Unit Secretaries, ED Physicians, House Nursing Supervisors and he Caledonia County Sheriffs who are contracted to provide Security Services to NVRH. VT DMH has been contacted for available dates to provide specific de-escalation training to the above named categories of staff. The DMH training module titled ***De-escalation techniques to utilize in an ED*** will be the first in a series offered to the staff. Training of the initial identified staff members will be completed by 5/30/14. Colleen Sinon, RN, CPHQ, CPHRM, VP Quality Management and Debra Bach, RN, MSN, CEN, Emergency Services Director are responsible for coordinating the training with VDH and achieving 100% compliance with the training expectation for the identified population.	
C 271	485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on record review, staff interview and general observation the hospital failed to provide health care services in accordance with their own written policies for one of six patients (# 1) selected for review. Findings include:	C 271	C 271 485.635(a)(1) PATIENT CARE POLICIES **Response is located on Page 3 of 5**	

Peter Burt CEO 3/24/2014

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C 271	Continued From page 2 Patient # 1 was admitted into the emergency department on a voluntary basis on December 6, 2013. [S/he] presented with increasing anxiety and apparently the admission process itself caused the patient to further decompensate as evidenced through mental health, nursing, and physician notations. Per record review the patient decompensated to the point that the emergency department physician felt compelled to physically take the patient to the floor and request the contract sheriff deputy to handcuff the patient. Per review of the hospital protocol titled Restraints and Management of a Restraint- Free Environment, effective 04/92 and reviewed last on 12/13, the hospital staff did not intervene according to their written protocol, specifically as follows; Per hospital protocol as listed, in the section identified as Supportive Data, it states that the decision to use a restraint is not driven by diagnosis, but by a comprehensive individual patient assessment which includes a physical assessment to identify medical problems that may be causing behavior changes in the patient. The physician did not seek information regarding the presentation of the patient, whether medical issues were involved or whether any evaluation had occurred, and approached the patient to tell [him/her]to go into [his/her] room. There was no attempt by the physician to inquire of the patient what [his/her] needs were or to assess the patient's needs. The following protocols in the restraint policy are also noted as not being followed; 1. Physical restraint types: Per hospital protocol handcuffs are not listed as clinical restraining devices. 2. C. General Guidelines: (2). The decision to	C 271	continued from page 2 of 5 **C 271 485.635(a)(1) PATIENT CARE POLICIES** The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. Based on interviews and record review the hospital failed to provide health care services in accordance with our own Restraints and Management of A Restraint Free Environment policy (attached) for Patient #1. Handcuffs were applied and are not listed as clinical restraining devices in our policy. Staff members were not formally trained in de-escalation techniques and alternatives to the use of restraints were not attempted. **Corrective Action Plan** 1. The Restraints and Management of a Restraint-Free Environment and Psychiatric Patient Management policies will be reviewed and revised to include contracted staff such as the Caledonia County Sheriff's Office staff currently providing security service to the hospital. Revisions will be completed by 5/14/14. Debra Bach, RN, MSN, CEN, Emergency Services Director is responsible for coordinating the policy revision. 2. All ED Staff (Nurses, Technicians and Secretaries) will receive education on the newly revised policies at the May 14, 2014 Departmental meeting. The mid-level providers will receive education by May 16, 2014. Debra Bach, RN, MSN, CEN, Emergency Services Director is responsible for providing the education and achieving 100% compliance. 3. All ED physicians will receive education on the newly revised policies by May 16, 2014. Dr. William Sargent, ED Medical Director is responsible for providing the education and achieving 100% compliance.	

PLR By T CEO 3/24/2014

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C 271	Continued From page 3 increase environmental restrictiveness must be based on the assessed protective and safety needs of the patient and/or others. In this case per interview the physician had just arrived for {his/her] shift and heard the patient yelling. [S/he] did not have information regarding the condition of the patient, the needs of the patient, or make an attempt to assess the patient for intervention purposes. Per interview the physician stated [s/he] approached the patient and told [him/her] to go back into [his/her] room. The patient became aggressive at that point. 3. C. General Guidelines: (3). Alternatives to restraints will be attempted initially. No alternatives were attempted or even considered.There is no documentation in the clincal record supportive of the nurse or the physician attempting to de-escalate the patient or that they conferred on a plan to intervene with the patient, or that there was any consideration for lesser restrictive interventions. On March 6, 2014 at 0730 AM the physician who intervened with the patient and requested that the contract officer handcuff the patient confirmed that [s/he] did not attempt to assess the patient and did not include the physical intervention or the use of the handcuffs in [his/her] discharge summary or any other component of the medical record. The physician at this time also confirmed that [s/he] is aware that the hospital has a restraint policy that does not include the use of handcuffs.	C 271	C 271 485.635(a)(1) PATIENT CARE POLICIES **Response is located on Page 3 of 5**	
C 302	485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by:	C 302	C 302 485.638(a)(2) RECORDS SYSTEMS **Response is located on Page 5 of 5**	

P & R Bay CEO 3/24/2014

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C 302	Continued From page 4 Based on record review and on staff interview the Critical Access Hospital staff failed to accurately document a clinical intervention in one of six medical records reviewed. Findings include: Patient # 1 was admitted to the hospital emergency department on 12/06/2013. Per record review there was no documentation by the primary nurse involved in the care of the patient, or the the physician treating the patient that a physical intervention and subsequent use of restraining devices had occurred. Per interview on March 5, 2014 at 2:30 PM, the primary nurse providing care to the patient confirmed that [s/he] did not enter documentation into the patient record regarding an actual event that [s/he] witnessed regarding the physical take down of a patient and subsequent handcuffing of that patient. When asked why [s/he] failed to to so [s/he] stated that the shift in question included a multitude of anxiety provoking events involving several patients and that [s/he] did not get to it. Per interview on March 6, 2014 at 0730 AM the physician of record confirmed that [s/he] did not document the physical take down and subsequent handcuffing of a patient. The physician stated that the incident happened quickly and the handcuffs were on for only five minutes.	C 302	***C302: 485.638(a)(2) RECORDS SYSTEMS*** ***The records are legible, complete, accurately documented, readily accessible, and systematically organized.*** Based on staff interviews and record review the staff failed to accurately document a clinical intervention in one of six records reviewed. The electronic record for Patient #1's Emergency Department visit on 12/6/13 did not contain Physician or Nursing documentation of the physical intervention and subsequent use of a restraining device. **Corrective Action Plan**: 1. To support and facilitate accurate documentation, the electronic templates for nursing and physician documentation will be reviewed and revised to include all aspects of de-escalation and restraint use outlined in the associated policies Debra Bach, RN, MSN, CEN, Emergency Services Director and Dr. William Sargent, Medical Director, are working collaboratively and are jointly responsible for ongoing monitoring of Nursing and Provider documentation compliance according to policy. Revisions will be fully implemented by 5/30/14.	

P & R Bey CEO 3/24/2014

NORTHEASTERN VERMONT REGIONAL HOSPITAL

TITLE OF PROTOCOL:
RESTRAINTS AND MANAGEMENT OF A RESTRAINT-FREE ENVIRONMENT

SUPPORTIVE DATA: ALL patients have the right to be free from physical or mental abuse, and corporal punishment. ALL patients have the right to be free from restraint of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

Northeastern Vermont Regional Hospital is committed to creating a physical, social, and cultural environment that limits restraint use to be imposed only to ensure the immediate physical safety of the patient, a staff member, or others. The decision to use a restraint is not driven by diagnosis, but by a comprehensive individual patient assessment which includes a physical assessment to identify medical problems that may be causing behavior changes in the patient.

The restraint regulation applies to: All hospitals (acute, long-term care, psychiatric, children's and cancer) All locations within the hospital (including medical/surgical units, critical care units, forensic units, emergency department, psychiatric units), etc. and All hospital patients regardless of age, who are restrained

CRITERIA FOR RESTRAINTS:
A. Physical abuse to patients or staff
B. Self injury behavior
C. Verbally aggressive (extreme) leading to potential harm of self or other

A. DEFINITIONS:
Physical Restraints - Any manual method, physical or mechanical device, materials, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. In addition to vest restraints and limb restraints, other types of restraint include the following:
a. Physically holding a patient with force to administer a medication against a patient's will. (This includes administration of psychotropic medication)
b. Net bed or "enclosed bed" unless used for toddler placement
c. Tucking a patient's sheets in so tightly that the patient cannot move
d. Recliners if the patient cannot easily get out of the chair on his/her own.

Exclusions:
Orthopedically prescribed devices
Surgical dressings or bandages
Arm board used to stabilize an IV (unless the arm is tied down)
Protective helmets
Hand mitts that do not immobilize the fingers or hand and are not used with wrist restraints or any other form of restraint.
Physical holding of a patient for the purposes of conducting routine physical exams or tests. However, the patient has a right to refuse a medical exam.

Devices to protect the patient from falling out of bed - Examples include raising all the side rails when:
1. A patient is on a stretcher or bed recovering from anesthesia
2. The patient is sedated or received pain medication
3. The patient is experiencing involuntary movement, such as a seizure
4. A patient is on certain types of therapeutic beds, e.g. rotating bed
5. A patient would be unable to voluntarily exit the bed due to his/her physical condition. (Raising the side rails has no impact on the patient's freedom of movement.)
   The use of 2 upper side rails on a four-rail bed

Legal restraints such as handcuffs and shackles which are monitored by designated security/police officers
Quadriplegic patients when sitting in a chair

Physical restraint types:
1. Vest restraints if used to confine
2. Tabletop chair if used to confine
3. Ankle or wrist restraints
4. Three-point (Considered EMERGENT and should be used for patient at imminent danger to themselves or others .
5. Four point restraints

Chemical Restraint - A drug or medication used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and not a standard treatment or dosage for the patient condition. (Psychotherapeutic medications used as a standard treatment for the patient's psychiatric condition or medical condition with the goal to assist the patient to effectively and appropriately interact with the world around them is not considered a restraint.)

B. PERSONNEL:
Any nursing personnel may use alternative methods to minimize the need for restraints (See Appendix B)
A nurse who has received training and demonstrates knowledge in the specific needs of a patient population as it applies to the following:
1. Identifying staff and patient behaviors as well as environmental factors that may trigger circumstances that require use of restraints
2. Identifying the risk of restraint use in vulnerable patient populations such as emergency, pediatric, cognitively or physically limited patients
3. The use of non-physical intervention skills
4. Choosing the least restrictive interventions based on an assessment of the patient's behavioral and medical status
5. Identifying specific behavioral changes that indicate restraint is no longer necessary
6. Monitoring the physical and psychological well-being of the patient in restraints
7. Safe application of restraints

Based on this training,the nurse is authorized to initiate restraint and/or perform evaluations or re-evaluations of patients in restrains and to assess their readiness for discontinuation or establish the need to secure a new order.

Licensed Independent Practitioner (LIP)
Physicians are granted special licensing privileges by the States to order medical treatment as outlined by their scope of practice.

C. GENERAL GUIDELINES:
1. Patients will be maintained in the least restrictive, yet safe environment.
2. The decision to increase environmental restrictiveness must be based on the assessed protective and safety needs of the patient and/or others.
3. Alternatives to restraints will be attempted initially.
4. Once alternatives to restraints have been considered, attempted or failed, and the patient's safety and/ or well being is still at risk, the use of a restraint may be necessary
5. Determining the type of restraint to use involves the application of two criteria:
   a. "Least restrictive" refers to the smallest amount of mobility being lost by the patient.
   b. Safety is provided to the patient, staff and others.

6. Restraints may be applied upon the assessment of a qualified RN when no other restraint alternative methods are effective. An LIP order is required prior to or immediately (within minutes) following the application of all restraints.

The order must include the following:
a. The date and time the order was received
b. The type of restraint utilized
c. The reason for the restraint
d. Duration of restraint

7. If the ordering physician is not the attending physician, the attending physician or his/her designee must be notified within 24 hrs of receipt of the order per medical staff bylaws.
8. PRN orders for restraints are not acceptable.
9. Telephone orders must be countersigned dated and timed by the physician within 48 hrs of receipt of order per medical staff bylaws.

D. PATIENT OUTCOMES
1. To identify patients' basic rights, ensure patient safety, and eliminate the inappropriate use of restraints.
2. To have alternatives considered prior to implementing any restraint.
3. Restraints will only be used if necessary to ensure the immediate physical safety of the patient, staff member, or others and will have the least possible restraint applied and used for the shortest period of time.
4. The choice of restraint will respect the dignity, autonomy and independence of the patient.
5. Include information to home health, home care attendant or long term facility on needs and use of any protective device.

ASSESSMENT (initial)
The RN will assess the following prior to restraint use:
1. Past medical history
2. Vital signs including pain
3. Patient's physical and cognitive status and limitations.
4. Inform the ordering physician if the initiation of the restraint is based on a significant change in the patient's condition.
5. Swallow/gag reflex
6. Ability to turn head/neck and other mobility functions to protect the airway.

ASSESSMENT (continued)
Ongoing assessment and monitoring of the patient's condition by a physician, or trained staff is crucial for prevention of patient injury or death as well as ensuring that the use of restraint is discontinued at the earliest possible time. The selection of an intervention and determination of the necessary frequency of assessment and monitoring should be individualized with consideration of variables such as:
1. Patient's condition
2. Cognitive status
3. Risks associated with the use of the chosen intervention
4. Factors which may require periodic (every 15, 30 minutes, etc.) or continual (moment to moment)

PLANNING
1. Patient/Family Teaching:
   a. The use of alternatives to restraints, the use of a restraint, and the necessary behaviors a patient must exhibit before discontinuing the use of a restraint device should be explained to the patient, and when appropriate, the family. If the use of restraints becomes necessary, it will be explained that our goal is to discontinue them as soon as the patient exhibits expected behaviors.

b. When a pediatric patient must be restrained, an explanation of the purpose and duration of the restraint must take place with the patient and/or family. Consideration must be given to the child's cognitive and developmental abilities. Patient and family involvement should be documented.

2. Patients at risk of harming self or others, the RN will determine appropriate type and size of restraint.
   a. Assess cause for which restraint is being considered.
   b. Develop alternatives
   c. Consider alternatives prior to applying restraint

IMPLEMENTATION

1. If patient assessed to be at risk for harming self or others, initiate alternative modalities
   The first state of management includes using alternatives if time permits. (See appendix B)

2. If alternatives are unsuccessful and the RN determines restraints are necessary, the least restrictive measure will be employed.
   - Hard restraints are located in Emergency Dept. and ICU
   - Soft restraints are located on all inpatient units and Emergency Dept.
3. Physician order for type of restraint and time limit is necessary prior to initiation of restraints EXCEPT in emergency situations. Although an order can state up to 24 hours, every attempt is made to remove restraints as soon as feasibly possible.
   Restraints may be ordered for the following time limits:
   a. General Adult population - 24 hours
   b. Primary behavioral health needs population - Patients who exhibits violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to total of 24 hours:
      * 1 hour for children under the age of 9
      * 2 hours for children/adolescents (9-17)
      * 4 hours for adults
4. When restraint is used to manage violent or self-destructive behavior, a physician or other LIP must see the patient face-to-face within 1-hour after the initiation of the intervention to evaluate:
   a. the patient's immediate situation
   b. the patient's reaction to the intervention
   c. the patient's medical and behavioral condition; and
   d. the need to continue or terminate the restraint
5. Apply the restraint/s ordered following manufacturer's guidelines/directions.
   If attachment to bed required, secure to bed frame or springs NOT side rail to allow side rail to move without injuring patient.
6. Evaluate the need for continued restraints at least every 2 hours.
7. Nursing Administrator or Risk Manager should be notified of any patient in restraints.

EVALUATION

Evaluation includes patient ability to cooperate and reduction of behavior (s) warranting restraints with documentation via Meditech Process Intervention (PCI).

DOCUMENTATION (initial - within 1 hour of initiation)

1. Restraint Application Intervention which includes the RN assessment
2. The identity of the provider who ordered the restraint
3. Behavior exhibited
4. Intervention used - physical restraint or chemical restraint
5. Failure of alternative methods to provide protection
6. Type of protective device used and that it is the least restrictive
7. Times in use, times removed

8. Condition of skin and circulation, repositioning, any observations
9. Assessment/reassessment for continued need for restraining
10. Any knots required should be tied to permit quick release
11. Discontinuance of restraint use

DOCUMENTATION (continued)

1. Document on Restraint Assessment Intervention every 2 hours to include
   A. Circulation is not occluded or skin pressure is not excessive
   B Observe for:
      a. restraint position
      b. body alignment
   C. Response to intervention(s) used, including the rationale for continued use
      a. level of distress and agitation
   D. Times in use, times removed
   E. Mental status
   F. Cognitive functioning
   G. Neurological evaluation
   H. Alternatives attempted every shift

2. Remove restraints for 5-10 minutes every 2 hours during normal waking hours and at least every 4 hours during sleep. (Unless dangerous to self or others then loosen or remove one extremity at a time) Care to include: toileting, checking for incontinence, providing ROM and beverage and/or snack
3. Evaluation includes patient ability to cooperate and reduction of behavior(s) warranting restraints.

E. RENEWAL OF ORDERS

1. During the time an existing order is in effect, restraints may be reapplied using this order based on RN assessment. The maximum for all orders is a total of 24 hours.
2. When the original order expires, a face-to-face reassessment by a licensed independent practitioner is required prior to reordering.
3. For patients with primary behavioral needs the RN will perform the reassessment and make a decision to continue the original order as indicated on physician order sheet.

F. REPORTING DEATHS RELATED TO RESTRAINT (A-0214)

1. The organization must report to Center for Medicare and Medicaid Services (CMS) any patient death that occurs:
   a. During restraint
   b. Within 24 hours after removal of restraint
   c. Each death known to the hospital that occurs within one week after restraint where it is reasonable to assume that use of restraint directly or indirectly contributed to a death.
   "Reasonable to assume" includes but not limited to deaths related to restrictions of movement, death related to chest compressions, restriction of breathing or asphyxiation. Reporting includes deaths in soft wrist restraints.
2. The nurse will notify the nurse supervisor if he/she answers "yes" to the question "Has the patient been in restraint in the last 7 days?" on the record of death.
3. Notify Risk Manager for instruction immediately.
4. CMS must be notified of the death on the first business day following the hospital's knowledge of the death by the Risk Manager or designee.

EDUCATION/COMPETENCY

Will be determined by Nurse Education Department

REFERENCES:
- CMS Conditions of Participation
- Sue Dill Calloway RN Esq. CPHRM AD,BA,BSN,MSN,JD "What Hospitals Need to Know About Restraint and Seclusion."
- Seclusion and Restraints, Summary Table of Seclusion and Restraint Statutes, regulations, policies and Guidance, By State and Territory Author

APPROVAL: Veronica Hychalk MS, RN 02/01/2012
Vice President Professional Services Date

Dr. Rousse 02/01/2012
Chairperson Medical Committee Date

EFFECTIVE DATE: 4/92

REVISION DATES: 2/94 7/96 9/06 2/07 5/07 12/11

REVIEW DATE: 12/13

REVIEWED: 12/11

ADDENDUM A
List of Possible Alternatives
Alternatives to Restraints

Table 1: Generic

Alternative	Strategy
Monitoring	Companionship: staff or family stay with patient Room near or visible from nursing station
Comfort Measures	Comfortable positioning and clothing. Gentle touch
Soothing Environment	Appropriate lighting (dim light calms). Relaxing music (or nature sounds) that patient finds appealing – try headset. Decrease use or volume of intercom, turn off telephone in-room ringer during sleep. Call light accessible at all times.
Familiar Environment	Put bed & Chairs where patient wants them, if possible. Familiar objects or personal belongings
Interpersonal Skill	Calm reassurance: relaxed posture, smiling acceptance. Pleasant, consistent interaction
Consistent Staff	Assign staff familiar to patient: same staff as often as possible.
Regular Toileting	Every two hours while awake and 1-2 times a night
Purposeful Act	Relate it to patient's interest and work history. Stimulus objects: puzzles, sorting. Confused patients: sort papers, fold towels, use books with zippers, buttons, textures; objects with turning knobs, dials.
Distraction	Video or photographs of familiar people/places Engage in conversation.
Opportunities for Control	Give choices, solicit patient or family ideas for alternatives.

Table 2 - Fall Prevention

Alternative	Strategy
Room Modification	Nonskid strips on floor beside bed, path to toilet. Eliminate or diffuse glass. Eliminate severe shadows. Ensure optimal lighting (2-3 times normal intensity). Remove unnecessary furniture & equipment. Provide assistive devices (i.e. grab bars). Gym mat beside bed to cushion a fall Avoidance of "busy" floor patterns
Furniture Modification	Bed/chair exit alarms. Slanted chair seats. Nonslip wedge or beanbag chair cushions Lower bed (18" top of mattress to floor) if possible. Wheels removed from over bed table and bedside tables. Use no bed side rails or 1/2 or 3/4 if patient requests.
Equipment Modification	Bed wheel locks or stabilizers. Wheelchair anti-tip devices Call light pinned to gown or through sleeve. Positioning devices Nonskid properly fitting footwear
Consultation	Physical Therapist - ambulation, gait training, ambulation devices

Table 3: Interference with Treatment

Alternative	Strategy
Exploration	Guide patient's hand through gentle exploration of device.
Treatment Modification	Discontinue urinary catheter, toilet frequently. Heparin-lock intravenous line Substitute gastrostomy tube for nasogastric tube.
Treatment Consolidation	Modify intravenous treatments and give through nasogastric tube, when possible, thereby eliminating one tube.
Treatment Disguise	Keep intravenous solution bags behind patient's field of vision. Apply loose binder, stockinette or clothing over tubes or dressings.
Equipment	If patient agrees and does not find these restrictive: Apply air splint to stabilize joint. Pad site of bothersome treatment or dressing. Foam finger extenders, ski mittens or garden gloves with fingers cut out.

Table 4: Agitation and Confusion

Alternative	Strategy
Environment	Dim lighting.
Modification	Familiar room layout and belongings Minimal stimulation and noise
Energy Redirection	Broad-based rocking chair for vestibular stimulation. Assisted ambulation
Treatment Modification	Less bothersome form of treatment Rearrange or combine procedures or treatments to permit uninterrupted sleep.
Interpersonal	Validate concerns.
Interaction	Repeated reassurance. Calm acceptance. Patient's person choices considered.

25 ALTERNATIVES TO THE USE OF RESTRAINTS

1. Involve all departments in exercise programs, walking, range of motion and regular physical therapy.
2. Approach in a slow, non-threatening manner.
3. Allow wandering if possible and safe.
4. Listen/be attentive.
5. Massage/therapeutic touch/warm baths.

6. Pillows and other positioning aids.
7. Lap trays or velcro seat belts.
8. Food.
9. Warm beverages.
10. Pad dangerous corners of furniture.
11. Spend time researching cause of behavior and treat. (i.e. remove source of stimuli)
12. Verbal support/encouragement.
13. Verbal instructions - speak clearly.
14. Garden tours or outdoors during warm weather.
15. Diversional activities such as:
    a. T.V./videos
    b. Music therapy
    c. Air bags
    d. Bingo
    e. Picture books
    f. Stories, etc.
16. Encourage outings with family and friends.
17. Allow choice in activities.
18. Frequent visits from family, volunteers, Boy Scouts, Girl Scouts, church groups.
19. Be calm and self-assured. SMILE....
20. Provide a structured, consistent and somewhat quiet environment.
21. Lower beds or place mattress on the floor (if permitted by infection control).
22. Lower chairs/rocking chairs.
23. Toileting, as required.
24. Volunteers as "buddies".
25. Have family and staff support/discussion groups.

NORTHEASTERN VERMONT REGIONAL HOSPITAL

TITLE OF PROTOCOL: Psychiatric Patient - Management

OUTCOME: All Patients presenting to the ED for help with a suspected Psychiatric diagnosis will be evaluated initially by the ED provider and then by the on-call Northeast Kingdom Human Service's (NKHS) Crisis Clinician.

The patient will be cared for in the same manner as all other patients presenting to the ED for care. At all times the patient's dignity should be maintained as long as safety for the patient and the staff can be assured.

The ED provider, in collaboration with the NKHS crisis clinician, will ensure appropriate disposition of the mental health patient. This may include admission to NVRH or transfer to another facility for appropriate care, treatment, crisis planning, and discharge planning.

KEY POINTS:

- The patient will be triaged and registered per admitting protocol. If patient presents with indications of suicidal tendencies, they will be closely monitored and asked to change into paper scrubs or a hospital gown if appropriate. All personal items will be removed, placed in a hospital bag, and secured at the nurse's station as long as the patient is in the department.

- All patients presenting with a potential psychiatric diagnosis should be triaged at an ESI level 2.

- Patients presenting with potential psychiatric issues should be placed in room 9 or room 5 to allow close monitoring. Prior to bringing the patient to either room, all equipment, supplies, removable items should be removed from the room and stored away from the patient's reach.

- ED provider will complete a medical screening exam to ensure medical stability. If adequate information is available regarding the patient on their arrival, the ED provider may contact mental health to request assessment prior to receiving completed lab reports, etc.

- ED provider or designee will contact the on-call crisis clinician using the main NKHS number (802-748-3181), including after hour when clinicians are paged. The NKHS crisis clinician will respond to the ED and offer approximate time of arrival (within one hour).

- A supervisor, a member of the medical staff, and/or a psychiatrist (if available) from NKHS will be available for consultation to the crisis clinician and ED as appropriate.

- If deemed appropriate for admission at NVRH, the ED provider will contact the on-call physician for admission orders.

- The crisis clinician will collaborate in the admission process discussing the admission directly with the on-call physicians involved.

- The admitting physician will decide if definitive care will be completed at NVRH or transferred to another facility in the case of a more complicated psychiatric presentation.

- It is the responsibility of the NKHS crisis clinician to arrange admission to an inpatient psychiatric facility or a crisis stabilization program if the on-call physician denies admission to the facility (NVRH). The Crisis Clinician and the ED provider will collaboratively determine the most appropriate means of transportation to the facility.

- The ED provider is responsible for completion of all transfer paperwork required under EMTALA.

- If the patient is transferred to another facility and the ED provider and/or ambulance deem it necessary. Providers will work collaboratively to determine personnel necessary for transfer. The NKHS staff is not required to accompany the patient. Human Service's staff, or designee, may be asked to accompany the patient if the ED provider and/or ambulance personnel deem it necessary.

- When inpatient psychiatric hospitalization is deemed necessary by all parties to ensure patient and community safety and the patient is not in agreement, involuntary hospitalization (EE) procedures will be followed. When an NKHS psychiatrist is not available to assist the qualified mental health professional (QMHP) in the evaluation, a hospital physician approved by the Department of Mental Health can assist with the procedure. When no physician is available, court warrant procedures will be enacted. See Involuntary Commitment policy

REFERENCES: Northeast Kingdom Human Services
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Clinical Director of Children's and Adult MH & SA

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